Columbia Community Mental Health APPLICATION FOR SERVICES

***PLEASE READ*:** Columbia Community Mental Health is a private, nonprofit community mental health agency. Our professional staff is committed to providing quality counseling and case management services to the needs of all members of our community who are in mental or emotional distress. Most treatment is in the form of brief counseling and intervention. If we believe it would be helpful, we will refer you to one of a number of ongoing psychotherapy groups.

A SPECIAL NOTE FOR PARENTS*:** We believe that ***parents are the most important members of their children's treatment team. Because of this, parents of children receiving treatment at Columbia Community Mental Health are required to participate in the treatment of their children. We cannot help your child without your active cooperation and participation.

NAME: _____
First Middle Last Last Name at Birth

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ AGE: _____

PARENT/FOSTER PARENT'S NAME (If client is a child): _____

STREET ADDRESS: _____
City State Zip

MAILING ADDRESS, IF DIFFERENT: _____
City State Zip

PHONE: Home: _____ Work: _____ Msg/Cell(circle one): _____

DRIVERS LICENSE # _____

EMERGENCY CONTACT: _____ RELATIONSHIP_____PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRED BY: _____ PHONE: _____

Household information: Please list all people in the household.

	Name	DOB	Relationship to client
Person 1(client)			Client
Person 2:			
Person 3:			
Person 4:			
Person 5:			
Person 6:			

Please check all the following that apply **TO THE CLIENT**:

GENDER
- ☐ Male
- ☐ Female

RACE
- ☐ White (Non-Hisp)
- ☐ Black (Non-Hisp)
- ☐ Native American
- ☐ Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Hispanic (Mexican)
- ☐ Hispanic (Puerto Rican)
- ☐ Hispanic (Cuban)
- ☐ Other Hispanic
- ☐ Southeast Asian
- ☐ Other Race/Ethnicity

MARITAL STATUS
- ☐ Never Married
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Living as Married

HIGHEST GRADE COMPLETED:

_____
Enter K-17 **or**
0 for None or GED

LIVING ARRANGEMENTS
- ☐ Private Res-Alone
- ☐ Private Res-w/Sig. Other
- ☐ Private Res-w/Parent
- ☐ Non-Rel Foster Home
- ☐ Institution (Hospital/Corr)
- ☐ Private Res-Friends
- ☐ MH: Res Tx Fac/Home
- ☐ MHT x Fstr Care (Yth)
- ☐ MH: Other
- ☐ Group Home
- ☐ Transient/Homeless
- ☐ A&D: Refused/Unknown
- ☐ Unknown

EMPLOYMENT STATUS
- ☐ Employed Full-time (35+ hrs.)
- ☐ Part-time (17-34 hrs.)
- ☐ Irregular (less than 17 hrs.)
- ☐ Not Employed, Looking
- ☐ Not Employed, not Looking
- ☐ Retired
- ☐ Temp Layoff
- ☐ Seasonal
- ☐ Student
- ☐ Incarcerated
- ☐ Homemaker
- ☐ Unable

SOURCES OF INCOME
- ☐ None
- ☐ Wages, Salary
- ☐ OSIP - State
- ☐ Alimony/Child Support
- ☐ Social Security
- ☐ Public Assistance
- ☐ SSI - Federal
- ☐ Pension, Unemployment, VA
- ☐ Unknown
- ☐ Other
- ☐ Dividends/Interest
- ☐ Refused

Monthly Household Income:
$_____

INSURANCE COVERAGE
- ☐ Oregon Health Plan: G.O.B.H.I.
- ☐ Oregon Health Plan: Open Card
- ☐ Medicare
- ☐ Tricare
- ☐ VA
- ☐ Private Insurance: Please Name:

_____
- ☐ Self/None

Veteran
- ☐ Yes
- ☐ No

PLEASE DESCRIBE BRIEFLY THE PROBLEM YOU WANT HELP WITH (Use back of page, if necessary): _____
_____ ☐ More on back.

PLEASE LIST ALL OTHER AGENCIES FROM WHICH YOU RECEIVE ANY KIND OF SOCIAL SERVICES:_____
_____

SIGNATURE: _____ **DATE:** _____